

Personal Choice

Summary of Benefits



Temple University

Personal Choice® our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through Personal Choices expansive network of hospitals, doctors, and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With Personal Choice...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network ¹
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE		
Individual	\$0	\$100**
Family	\$0	\$300**
AFTER DEDUCTIBLE, PLAN PAYS	100%	100%, inpatient/outpatient hospital facility charges, ^{**} 80%, for other charges
OUT-OF-POCKET MAXIMUM (includes coinsurance only)		
Individual	None	\$1,000
Family	None	\$2,000
LIFETIME MAXIMUM	Unlimited	Unlimited

¹ Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Personal Choice, and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of the Independence Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. For services rendered by hospitals and other facility providers in the local service area, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year, but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

** Out-of-Network deductible does not apply to inpatient and outpatient facility charges.

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at \$0 at the beginning of each calendar year on January 1.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.



Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

Benefit	In-Network	Out-of-Network ¹
DOCTOR'S OFFICE VISITS		
Primary Care Services	\$5 Copayment	80%, after deductible
Specialist Services	\$5 Copayment	80%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	80%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%	80%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age ²	100%	80%, NO deductible
MAMMOGRAM	100%	80%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per year ²	100%	80%, after deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%	80%, after deductible
MATERNITY		
First OB visit	100%	80%, after deductible
Hospital	100%	100% ^{**3}
INPATIENT HOSPITAL SERVICES	100%	100% ^{**3}
INPATIENT HOSPITAL DAYS	365	120 ³
OUTPATIENT SURGERY	100%	100% ^{**}
EMERGENCY ROOM	\$25 Copayment (Copayment waived if admitted)	\$25 Copayment, (Copayment waived if admitted) NO deductible
AMBULANCE		
Emergency	100%	100%, no deductible
Non-emergency	100%	80%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	80%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	100%	80%, after deductible
THERAPY SERVICES		
Physical, Speech and Occupational	\$10 Copayment	80%, after deductible
Cardiac Rehabilitation 36 visits per year ²	\$10 Copayment	80%, after deductible
Pulmonary Rehabilitation 12 visits per year ²	\$10 Copayment	80%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum ²	\$10 Copayment	80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	\$10 Copayment	80%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	80%, after deductible

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2 Combined in/out-of-network

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness and substance abuse services

** Out-of-Network deductible does not apply to inpatient and outpatient facility charges.

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Benefit	In-Network	Out-of-Network ¹
SKILLED NURSING FACILITY	100%	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	80%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
MENTAL HEALTH CARE		
Outpatient	\$5 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible ³
SERIOUS MENTAL ILLNESS CARE		
Outpatient	\$5 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible ³
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	\$5 Copayment	80%, after deductible
Rehabilitation	100%	80%, after deductible ³
Detoxification	100%	80%, after deductible ³

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What Is Not Covered?

- Services not medically necessary
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service or supply
- Cosmetic services/supplies
- Routine foot care
- Supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- Dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Vision care (except as specified in a group contract)
- Military or occupational injuries or illness
- Benefits payable by the government, Medicare or through motor vehicle insurance
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Services or supplies that are experimental or investigative except routine costs associated with clinical trials
- Inpatient private duty nursing
- Alternative therapies/complementary medicine
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Contraceptives
- Maintenance of chronic conditions
- Immunizations required for employment or travel
- Self-injectable drugs

This summary represents only a partial listing of the benefits and exclusions of the Personal Choice program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully for a complete listing of the terms, limitations, and exclusions of the program. If you need more information, please call 1-800-ASK BLUE (275-2583).

Services That Require Preauthorization

Service	In-Network (Personal Choice [®] network provider or BlueCard [®] PPO provider)	Out-of-Network
ALL NON-EMERGENCY INPATIENT ADMISSIONS <small>(Except maternity admissions)</small>	Required	Required
Hyperbaric Oxygen	Required	Required
Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)	Required	Required
OUTPATIENT SURGICAL PROCEDURES		
Bunionectomy	Required	Required
Cataract Surgery	Required	Required
Cochlear implant surgery	Required	Required
Laparoscopic Cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia Repair	NOT Required	Required
Arthroscopic Knee Surgery/Diagnostic Arthroscopy	Required	Required
Obesity Surgery	Required	Required
Prostate Surgery	NOT Required	Required
Spinal/Vertebral Surgery	NOT Required	Required
Submucous Resection (nasal surgery)	Required	Required
Tonsillectomy and/or Adenoidectomy	Required	Required
RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES (for a complete list of these procedures, please see Benefits that Require preauthorization available on ibx.com)	Required	Required
Surgery for varicose veins, including perforators and sclerotherapy	Required	Required
Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies	Required	Required
TRANSPLANTS	Required	Required
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	NOT Required	Required
MRI/MRA	Required	Required
CT/CTA SCAN	Required	Required
PET SCAN	Required	Required
NUCLEAR CARDIAC STUDIES	Required	Required
OUTPATIENT THERAPIES: <small>Speech</small>	Required	Required
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES: <small>Skilled Nursing, Inpatient Hospice, Home Health, Birth Center</small>	Required	Required
MENTAL HEALTH CARE, SUBSTANCE ABUSE AND SERIOUS MENTAL ILLNESS TREATMENT		
Inpatient	Required	Required
Outpatient and Partial Facility	Required	Required
DAY REHABILITATION PROGRAMS	Required	Required
DENTAL SERVICES AS A RESULT OF ACCIDENTAL INJURY	Required	Required
NON-EMERGENCY AMBULANCE	Required	Required
DURABLE MEDICAL EQUIPMENT <small>Purchase items (including repairs and replacements) over \$500, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)</small>	Required	Required
PROSTHETICS AND ORTHOTICS <small>Purchase Items (including repairs and replacements) over \$500 (except ostomy supplies)</small>	Required	Required
INFUSION THERAPY IN A HOME SETTING	Required	Required
INFUSION THERAPY DRUGS <small>Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)</small>	Required	Required

Personal Choice network providers will obtain preauthorization for you, if it is required for the service provided. You are not required to obtain preauthorization when you are treated in a Personal Choice network hospital or facility or by a Personal Choice network doctor. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain prior approval.

If you use a provider who is a BlueCard[®] PPO network provider, or an out-of-network provider, you must obtain preauthorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain preauthorization.

Call Independence Blue Cross at the preauthorization telephone number listed on the back of your identification card to initiate preauthorization.

You may be responsible for financial penalties if you do not preauthorize services when you use a BlueCard[®] PPO provider, or an out-of-network provider. There is a \$1,000 penalty for failure to preauthorize inpatient services or treatment, and a 20% reduction in benefits for failure to preauthorize outpatient services or treatment.

Preauthorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preauthorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.